

Turning Point: A Special Report on the Refugee Reproductive Health Field

By Laurel Schreck

The United Nations High Commissioner for Refugees (UNHCR) estimates that 50 million people worldwide in 1999 had either fled their home country or had been internally displaced.^{1*} In some refugee settings, women and children are believed to comprise 80% of the population. Although this figure varies by setting, it is the women and children in all situations who are most vulnerable to the consequences of displacement,² including rape and sexually transmitted diseases (STDs).

Increasingly, emergency situations are the result of political conflict rather than natural disaster, which has led some to coin the term “complex political emergencies” to describe such situations. Often, these situations are not resolved quickly and cause a large number of people to be displaced, either within a country (internally) or across international borders (externally).³ Groups affected are diverse and require different health and humanitarian interventions, depending on their experiences prior to and during displacement.⁴

The changing nature of emergencies and several interrelated events of the last six years have drawn attention to the reproductive health needs of refugees, and a field of refugee reproductive health has emerged. Yet, despite some positive developments, delivery of reproductive health services to refugees remains uneven. Not all humanitarian relief organizations agree that reproductive health care should be a priority during an emergency, and there is insufficient research upon which to base policy or programmatic decisions.⁵ Because crises can be prolonged and have no clear end, the boundary between relief and development assistance is blurred.

According to Samantha Guy, manager of the Reproductive Health for Refugees Initiative at Marie Stopes International, “this is a critical time, a turning point for refugee reproductive health. It is time to transfer the policies and strategies that have been set in place at the headquarters

level to the field.”⁶ It is, therefore, an opportune time to examine how the field of refugee reproductive health emerged and what factors have contributed to, and limited, its growth.

Background

Gender analysis began to play a role in development activities during the United Nations (UN) Decade for Women (1976–1985). In the following years, interest in the special needs of refugee women grew.⁷ In 1989, UNHCR appointed a senior coordinator for refugee women to ensure that its policies designed to assist refugee women are implemented in the field. To increase women’s participation in program development, UNHCR adopted its Policy for Refugee Women in 1990, and the following year developed Guidelines on the Protection of Refugee Women. The latter provide staff and other humanitarian organizations with guidance on how to protect displaced women and girls from violence and abuse.⁸ Nevertheless, humanitarian agencies are not required to utilize UNHCR tools and guidelines, and they generally follow policies determined by their own organizational mandates.⁹

Despite advocacy for a more gender-conscious approach to development and increased recognition of refugee women’s unique set of needs, relief efforts through the late 1980s and into the early 1990s continued to focus on the traditional areas of assistance: food, water, shelter, sanitation and immunization. But by early in the 1990s, the lack of reproductive health care for refugees, particularly contraceptive services, began to draw attention.

Heightened Awareness

• *Former Yugoslavia and Rwanda.* From the early to the mid-1990s, two complex emergencies highlighted the reproductive health needs of refugee women. In 1991, war broke out in the Balkans, and by 1994 there were an estimated 700,000 Bosnian refugees and another two million people internally displaced in the former Yugoslavia.¹⁰ Bosnian women, accustomed to receiving family planning services, demanded that these continue.¹¹ The wide-

spread rape of women and forced pregnancy in Bosnia, reported extensively in the media, elicited a level of international concern about sexual and gender-based violence not previously seen.

In 1994, genocidal conflict erupted in Rwanda, displacing roughly two million people.¹² Once again, reports of sexual violence directed at women appeared in the media. Widespread disruption and displacement of the Rwandan population raised awareness of the importance of HIV-prevention efforts during humanitarian emergencies. Based on an AIDS assessment among Rwandan refugees in a camp in Tanzania, researchers were able to conclude that adolescent sexual activity might have increased since displacement, that commercial sex work had grown in the area surrounding the camp (although not within the camp itself) and that knowledge of HIV prevention was high but condom accessibility and usage were low.¹³ Furthermore, Rwanda’s contraceptive prevalence rate had been among the highest in Sub-Saharan Africa, and women and men reported to the team that they lacked access to family planning in the camp and that they had a strong interest in continuing to use it.

• *Refugee Women and Reproductive Health Care.* It has been six years since the Women’s Commission for Refugee Women and Children published its seminal report, *Refugee Women and Reproductive Health Care: Reassessing Priorities*.¹⁴ The report concludes that fertility is high in refugee settings and that many pregnancies are among women at high risk of obstetric complications. Where there were reproductive health programs for refugees at the time of the report, their focus was primarily on prenatal and delivery services

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*In this article, the term refugee is used to include both those who have fled their country of origin and those who have been displaced internally.

and the training of traditional birth attendants. In most settings, such areas as contraception, the prevention and treatment of STDs and HIV infection, and sexual and gender-based violence received little attention. Despite having been based primarily on anecdotal evidence, the report spurred great interest in the reproductive health needs of refugees and had a tremendous impact on the growth of the refugee reproductive health field.

• *International Conference on Population and Development*. The 1994 International Conference on Population and Development (ICPD) codified in its Programme of Action a broader, more expansive definition of reproductive health, placed within a rights context. Under pressure from nongovernmental organizations and activists, many of whom had been active in the Balkans crisis, the final Programme of Action included language on refugees, recognizing their "limited access to reproductive health care" and stating that:

Reproductive health care should be available in all situations and be based on the needs and expressed demands of refugees, particularly women, with full respect for the various religious and ethical values and cultural backgrounds of the refugees while also conforming with universally recognised international human rights.¹⁵

Furthermore, at this conference, the leaders of the United Nations Population Fund (UNFPA), UNHCR and the World Health Organization (WHO) pledged to work together to more effectively meet the reproductive health needs of refugees. According to Guy of Marie Stopes International, "the ICPD Programme of Action provided a mandate for many organizations and a backdrop against which the refugee reproductive health initiative could evolve and grow."¹⁶

Organizational Developments

Key United Nations agencies (such as UNHCR and UNFPA), bilateral donors (such as the U.S. and British governments) and nongovernmental organizations all now offer significant support, at least at the policy level, for the provision of reproductive health services to refugees. In the mid-1990s, two bodies formed to address the need for and absence of reproductive health services for refugees. The Reproductive Health for Refugees Consortium comprises seven nongovernmental organizations whose mission is to promote comprehensive reproductive health services for refugees through needs assessment, training, research and advoca-

cacy. The Inter-agency Working Group for Refugee Reproductive Health (IAWG), spearheaded by UNHCR and UNFPA, also advocates for increased reproductive health services as part of primary health care activities provided to displaced populations, and has designed tools and guidelines to facilitate this process.

The Consortium

In 1989, several of the International Rescue Committee's board members decided to form the Women's Commission for Refugee Women and Children to advocate for services for a population whose needs they believed were not being adequately addressed. Nonprofessional volunteers with the Committee had made site visits to refugee camps and had written reports about what they had seen; foremost for many of them was the lack of availability of contraceptive services in the camps.¹⁷

According to Mary Ann Schwalbe, the first director of the Women's Commission, she wrote to a number of donors about reproductive health services for refugees when she first arrived at the Commission, and none indicated any interest.¹⁸ Early in 1993, by chance, Schwalbe met Carolyn Makinson, program officer for the population program at the Andrew W. Mellon Foundation, who several months later asked her "what refugee women do for family planning and other reproductive health services." At that time, Schwalbe's answer was "very little," which was confirmed by searches of the literature and phone calls to numerous reproductive health and humanitarian organizations.¹⁹

Mellon then made a small grant to the Women's Commission to study the situation. A literature review yielded only a few descriptive studies with little mention of reproductive health, and a letter requesting information on family planning programs for refugees sent to roughly 50 international organizations also produced little. Further research was then conducted at six refugee camps and in two countries with internally displaced populations. This work led to the publication of *Refugee Women and Reproductive Health Care* in 1994.²⁰

After this report was published and another small grant was given to the Commission to publicize its findings, Makinson invited a group of organizations to her offices in August 1994; these later joined together to form the Reproductive Health for Refugees Consortium, with CARE, the International Rescue Committee, JSI Research and Training Institute, Marie Stopes International and the Women's Commission as members.²¹

These organizations represented a mix of skills and areas of expertise, including humanitarian assistance, reproductive health technical expertise and advocacy.²² Each organization received a grant of equal size for work in its particular area of expertise; JSI received an additional sum to provide subgrants to other organizations, particularly to local nongovernmental organizations, to increase refugees' access to services. Later the American Refugee Committee joined the Consortium, as did Columbia University's Heilbrunn Center for Population and Family Health, at the Joseph Mailman School of Public Health in New York.

Among the Consortium's accomplishments is development of a tool for relief workers to ascertain the reproductive health needs of displaced populations and to guide program activities. In addition, CARE has produced (for the Consortium) both a five-day training manual for health personnel, which covers such key areas as family planning, sexual violence, and STD and HIV prevention and treatment,²³ and a one-day training course to raise awareness of reproductive health issues among relief workers. JSI created a data bank on refugee reproductive health to hold materials critical to field staff and others who are involved in this area, including training curricula, program evaluations and policy-related publications.²⁴ Subgrants have been made to several local nongovernmental organizations, including one to Association Najdeh to provide health education workshops among Palestinian refugees in Lebanon and one to the Mae Tao Clinic for reproductive health services for displaced Burmese living in Thailand.²⁵ Finally, the advocacy efforts of the Consortium, both individually and collectively, have raised awareness among donors, policymakers, relief agencies and the public that the reproductive health needs of a population do not disappear once they have become displaced.

Consortium members had not worked together as a group prior to its formation, yet have been able to do so effectively for five years. The majority of participating organizations have chosen representatives to the group who have decision-making authority, which has facilitated the group's consolidation and has enabled it to accomplish concrete tasks.²⁶ Until recently, participants were all women who were committed to the issue and to the collaborative process.²⁷ Serious differences among groups on, for example, abortion did not impede members from working together. According to Barbara Smith, vice

president of overseas operations with the International Rescue Committee, "We did not try to become one agency. We always shared information and worked together on overarching issues. We built on our strengths as agencies and created new capacities."²⁸

Finally, the role of the donor in the success of the Consortium cannot be underestimated. Receiving three-year grants allowed a sufficient amount of time for reproductive health to become institutionalized within the participating organizations, and for the Consortium itself to solidify. Participants were encouraged to use donor funds only once they had determined how spending them in a particular way would help them to have funds for the issue in five years' time.²⁹ Smith pointed out that it is unusual in the relief world to have a three-year commitment from a donor. Typically there is a rapid turnover of grants, with donors funding no more than one year. "From the International Rescue Committee's point of view, it was phenomenal to have time to think something through."³⁰

The Inter-agency Working Group

Following the ICPD, in June 1995, UNHCR and UNFPA sponsored a symposium in Geneva on the reproductive health of refugees, in association with UNICEF and WHO. Although the first proposal for such a symposium was written in late 1993, it was not until the ICPD that symposium organizers believed there would be enough interest and support to proceed. Many participants who attended the symposium and who have been actively involved in follow-up activities insist that the meeting would never have occurred without the strong push given it by Daniel Pierotti, principal officer for crisis relief at UNFPA, and Serge Malé, chief of the Health and Development Section at UNHCR. Nafis Sadik, the executive director of UNFPA and the only UN agency leader to show strong interest in

the issue, also was instrumental in generating support for the meeting.³¹

UNFPA and UNHCR invited representatives of UNICEF and WHO, relief agencies, reproductive health organizations and bilateral donors to the first of three preparatory meetings for the June symposium. It was at this meeting in December 1994 that participants began to assess the level of reproductive health services for refugees and to discuss ways to strengthen them. It was also at this first meeting that participants set objectives for the symposium and identified what they considered to be the technical components of reproductive health in refugee situations, including safe motherhood; family planning; STDs, including HIV and AIDS; sexual and gender-based violence; and abortion services.³² To accomplish its overall objective of institutionalizing reproductive health in refugee situations, participants decided that drafting a refugee-specific field manual, covering the technical components they had identified, should be the primary objective of the June meeting. By the June 1995 symposium, working groups had produced a draft manual for discussion.

At the symposium, attended by representatives from more than 50 UN agencies, governments and nongovernmental organizations, Sadako Ogata, the high commissioner of UNHCR, and Nafis Sadik signed a joint Memorandum of Understanding, promising the two agencies' collaboration on this issue. Their high-level endorsement was critical, particularly for those organizations and governments that were not already fully committed. The IAWG was formed at this meeting, with roughly 32 members from UN agencies, nongovernmental organizations, research organizations and governments, and with UNHCR in a coordinating role. Government support, particularly that of the United States, was key. The U.S. State Department funded the reproductive health coordinator position at UNHCR, which, according to Daniel Pierotti, "was an important stepping stone to institutionalization"³³ of the IAWG. Kate Burns, the first reproductive health coordinator, has been instrumental in making the IAWG a "forum for exchange."³⁴

The Inter-agency Field Manual

Building on the ICPD Programme of Action, the field manual strongly affirms the place of reproductive health within essential primary health care services to be delivered during an emergency. The manual details those services that are needed

in the first phase of an emergency (the Minimum Initial Service Package), such as prevention and treatment of sexual violence, and those that should follow when the situation has stabilized, such as contraceptive services. During the drafting of the manual, there was much discussion of the phases of a complex emergency and when in an emergency reproductive health concerns become valid, according to Beverly Tucker, associate director of field operations at Family Health International. "UNHCR and UNFPA insisted that reproductive health needs begin at day one, not discounting, of course, the need for water, safety and housing. For example, women come to the camp who have been raped."³⁵

The manual was endorsed by 33 UN, nongovernmental and government members of the IAWG.* Yet according to Smith of the International Rescue Committee, "whether reproductive health should be an emergency issue appears to have been resolved in theory, but in practice is still not accepted. Resource allocation remains an issue—in an emergency, are you going to bring in water or a condom?"³⁶

• *Minimum Initial Service Package.* To facilitate the provision of reproductive health services early in an emergency, the concept of the minimum initial service package, or MISP, was born. This is a set of activities, including equipment and supplies, that "can be implemented without any new needs assessment" at the outset of a crisis. The MISP calls for a reproductive health coordinator, who can serve as the focal point for all reproductive health activities, coordinate among agencies, interact with government authorities, introduce standardized protocols and provide training to personnel as well to the refugee population. Currently, there are not enough people with the technical skills to serve as coordinator, and the right model has not yet been found. With guidance from UNFPA and support from the Belgian government, a 10-day course will be available shortly to train health care practitioners and to improve their reproductive health skills.³⁷

Among the resources that the MISP identifies for use in an emergency is WHO's New Emergency Health Kit-98 (NEHK-98), which includes supplies for infection control, safe deliveries and management of obstetric emergencies, and treatment for victims of sexual violence. Additionally, UNFPA took the lead in developing a Reproductive Health Kit for Emergency Situations, which complements that of WHO and is based upon kits

*Signatories to the field manual are humanitarian organizations (such as the International Federation of Red Cross and Red Crescent Societies, Médecins du Monde and Médecins Sans Frontières) and other nongovernmental organizations (such as Family Health International, IPAS and the World Association of Girl Guides and Girl Scouts), research institutes (such as the African Medical and Research Foundation, the London School of Hygiene and Tropical Medicine and the Population Council), United Nations agencies (such as the United Nations Children's Fund and the United Nations Joint Program on AIDS) and government agencies (such as the U.S. Agency for International Development, the U.S. Centers for Disease Control and Prevention and the U.S. Department of State).

created by Marie Stopes International for use in Bosnia. This reproductive health kit comprises 12 subkits for use at different health care levels, among which are subkits of condoms, oral and injectable contraceptives, and drugs for the treatment of STDs. There are also subkits with emergency contraception for women who have been raped and manual vacuum aspiration equipment for the treatment of postabortion complications.

•*Emergency contraception and abortion.* Controversy emerged during discussion of the chapters of the field manual that deal with the treatment of survivors of sexual and gender-based violence and with abortion. U.S. Rep. Chris Smith (R-N.J.), a member of the U.S. House of Representatives and a longstanding foe of international family planning assistance, and others decried the availability of emergency contraceptives in refugee camps, calling them “chemical abortifacients.” Burns, IAWG coordinator, insists that the group “was guided by WHO, which says that emergency contraception, when used within the first 72 hours of intercourse, does not interfere with an established pregnancy and is not an abortifacient.” She asks, “why shouldn’t women have access to emergency contraception during an emergency if they would have had access to it as a nonrefugee?”³⁸

In its final version, the field manual recommends emergency contraception as a medical response for survivors of sexual violence in both the MISP and the sexual and gender-based violence chapters.³⁹ The latter includes WHO’s definition of post-coital contraception, with WHO’s acknowledgement that there is no consensus on how emergency contraceptive pills work and recommendation that a woman be provided with adequate information to allow her to make an informed choice.⁴⁰ A later chapter on family planning refers readers to the earlier sexual and gender-based violence chapter and states that “national policies and the demands of well-informed users should guide use of emergency contraceptive pills in refugee situations.”⁴¹ Sandra Krause, director of the Reproductive Health Program at the Women’s Commission on Refugee Women and Children, regrets that the field manual only recommends emergency contraception for women who have been raped, but emphasizes that a compromise such as this to satisfy critics of emergency contraception is what collaboration often requires.⁴²

The section on the treatment of postabortion complications, which is included in the field manual chapter enti-

led “Other Reproductive Health Concerns,” also relies heavily on the technical expertise of the WHO and the Post-abortion Care Consortium,* as well as on the ICPD Programme of Action. The Programme of Action states that abortions should be safe where they are legal and that services should be available to treat the complications of unsafe abortion. Nevertheless, Rep. Smith asserted that UNFPA, UNHCR and WHO planned to promote abortions among refugee women,⁴³ and he wanted to prevent manual vacuum aspiration from being available under most circumstances.⁴⁴ In response, Pierotti says, “we speak of the complications of abortion as an emergency in medical practice. When a woman is bleeding to death or is infected, you cannot say you have had an abortion and therefore we will not treat you. It’s an emergency and you treat.”⁴⁵

Some participants in IAWG discussions of the field manual expressed concern that the equipment required for manual vacuum aspiration also could be used to induce an abortion. Others, such as Peter Poore, who participated in the IAWG as senior health advisor with Save the Children (UK), said his primary concern regarding manual vacuum aspiration involved quality of care issues. In a 1998 letter to the editor of the *Sunday Observer*, he wrote, “Save the Children disagrees with the UN guidelines on the quality of care possible in some refugee camps, where minimum standards for safety are often not secure, and alternative measures need to be considered.”⁴⁶ In favor of offering manual vacuum aspiration to treat the complications of unsafe and incomplete abortions, Burns insists that manual authors followed WHO guidelines, which say that this is the more effective method and can be used to save lives.⁴⁷ In the end, Save the Children (UK) became a signatory to the manual

IAWG’s Achievements

The IAWG oversaw two years of field-testing of the field manual in 17 countries. The revised version, published in 1999, opens with a joint statement by WHO Director General Gro Harlem Brundtland, Sadik and Ogata and is widely available in the field. In less than two years, there have been 60 orders for the reproductive health kit, which is in use in more than 28 countries.

The commitment of so many diverse groups to continue to meet after five years is not insignificant. The meetings provide a forum where people can exchange information, receive advice and gain from

the experiences of others. According to Pierotti, “when reproductive health is considered as routine, we will no longer need to meet. That is not the case yet.”⁴⁸

The Future

At the fifth IAWG meeting in February 2000, the group identified several challenges that remain and areas that must be strengthened. Coordinating a response in emergency situations among agencies has been problematic, as has been the placement of reproductive health coordinators. In addition to the need to increase research among refugees, a more effective monitoring system for reproductive health indicators is needed. Program activities must be strengthened in some key areas, such as for adolescents and HIV and STD prevention and care and in response to sexual and gender-based violence.⁴⁹

Burns expresses concern that the funding for refugee programs “is in a state of confusion or flux.” She says that donors are now more willing to provide money for specific activities, such as for combating sexual violence or HIV and AIDS, but are less willing to fund core programs. According to her, this amounts to creating vertical programs, whereas integration has been and should continue to be the goal.⁵⁰ An official from the U.S. State Department worries that other donor governments rely too heavily on the U.S. government as a consistent source of funding for refugee reproductive health programs and have not played as great a role in this area as they should.⁵¹ Reproductive health, she says, should be a regular item on their agenda.

Furthermore, it has not been easy to bridge the divide between humanitarian and development assistance. As the character of emergencies has changed, relief agencies increasingly have been drawn into what traditionally have been considered development activities. A similar transition is occurring among development agencies, some of which are now involved in emergency relief services. Changes on the ground have driven the expansion of emergency response into the development phase. This reality challenges donors to respond more flexibly and to support longer term activities, which itself is a formidable task. There may be resistance from host-country governments, which may themselves need

*The Postabortion Care Consortium comprises AVSC, the International Planned Parenthood Federation, IPAS, JHPIEGO, Johns Hopkins University/Center for Communications Programs and Pathfinder

development assistance and may not want a refugee population to be permanently settled within their borders. Additionally, donors may also be reluctant to commit funding for the duration of time needed to create sustainable programs.

At this point, no one working in the area of refugee reproductive health questions the need for reliable data to guide policy and program development. Yet, all recognize the difficulty of collecting information on a population that is unstable, many of whom are scattered and not living in settled camps. Additionally, refugees exist in different phases of displacement (from flight to stabilization), further complicating data collection.⁵² The Consortium and Interaction, a membership organization that includes both development and humanitarian agencies, are sponsoring a research conference in December 2000 to provide a forum for Consortium members (which have all received funding to conduct research) and others to share their findings with policymakers, donors and other implementing organizations.

Additionally, Columbia University has received a three-year grant to create a data bank from the monitoring and evaluation of 10 geographically diverse project sites and to develop monitoring and evaluation guidelines for field use.⁵³ The programs, which are not research projects, vary by setting (covering either one aspect or multiple aspects of reproductive health, depending on existing services) and will provide basic data on population-level knowledge, attitude and behavioral changes. Staff from the 10 sites will meet with one another and attend regional meetings with other groups to exchange information, and will be encouraged to document their findings and present them at conferences.

There is no question that the context in which refugees live differs greatly from that of the general population. Nevertheless, according to Therese McGinn of Columbia University, "in all situations people's individual lives revolve around similar issues."⁵⁴ A population's reproductive health needs do not disappear upon displacement. A tremendous amount of work remains to be done to ensure that refugees receive reproductive health services from the time they are first displaced through stabilization and finally resettlement, should that occur. Although reproductive health quickly became an area around which policy de-

veloped and to which resources have been committed, continued advocacy is needed to fully establish its permanent place in the array of services provided during emergencies and in post-conflict settings.

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